Section 2

Speech-Language Pathology and Audiology Services

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1 General Information

This manual is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as *Section I: General Information of the Utah Medicaid Provider Manual* (*Section I: General Information*).

The information in this manual represents available services when medically necessary. Services may be more limited or may be expanded if the proposed services are medically appropriate and are more cost effective than alternative services. This manual specifies the reasonable and appropriate amount, duration, and scope of the service sufficient to reasonably achieve its purpose.

1-1 General Policy

As an optional program, speech-language pathology services and audiology services are non-covered programs for Medicaid members except adult pregnant women or members eligible under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) (Also known in Utah as Child Health Evaluation and Care (CHEC)). Note: Services traditionally provided in an outpatient hospital setting are a mandatory service.

In certain cases, if Medicaid staff determine that the proposed services are both medically appropriate and more cost effective than alternative services, the Agency may exceed this limitation.

Speech-language therapy and/or audiology services must have a physician referral, be pre-authorized (if applicable), and be provided by a speech-language pathologist**Error! Bookmark not defined.** or audiologist, respectively. The total medical care of each speech-language and/or audiology patient is under the direction of a physician. The provider reviews the plan of care and the results of treatment as often as the patient's condition requires. If in their professional judgment, no progress is shown, the provider is responsible for discontinuing treatment and notifying the physician of treatment discontinuance.

The expectation is that services are delivered in an efficient and economical manner and are safeguarded against unnecessary, unreasonable, or inappropriate use.

Throughout this manual “provider” is used to represent a speech-language pathologist or audiologist who is a Medicaid provider.

Note: Effective November 1, 2008, non-pregnant adults are NOT eligible for

- Speech-language services from community based outpatient providers.
- Audiology services related to testing for hearing aids or purchase of hearing aids.

Medical Necessity

Speech-language and audiology services are considered medically necessary only if there is a realistic expectation that the treatment will achieve measurable improvement in the client’s condition in a reasonable and predictable period of time.

Under State law, speech-language services may not be considered medically necessary if an EPSDT eligible member can receive services funded by the State Office of Education.

Speech-Language Therapy and Audiology Services

Speech-language therapy evaluation should consider audiological issues and other physical (organic) conditions restricting proper speech and language development. These must be addressed in a comprehensive treatment

plan which includes speech/language therapy. Speech-language therapy without such a plan may be denied until a comprehensive plan is documented and submitted for review.

1-2 Fee-For-Service or Managed Care

This manual provides information regarding Medicaid policy and procedures for fee-for-service Medicaid members. This manual is not intended to provide guidance to providers for Medicaid members enrolled in a managed care plan (MCP). A Medicaid member enrolled in an MCP (health, behavioral health or dental plan) must receive services through that plan. Refer to the provider manual, *Section I: General Information,* for information regarding MCPs and how to verify if a Medicaid member is enrolled in an MCP. Medicaid members enrolled in MCPs are entitled to the same Medicaid benefits as fee-for-service members. However, plans may offer more benefits than the Medicaid scope of benefits explained in this section of the provider manual. Please contact the MCP for further information.

Medicaid does not process prior authorization requests for services to be provided to a Medicaid member enrolled in an MCP when the services are the responsibility of the plan. Providers requesting prior authorization for services for a member enrolled in an MCP will be referred to that plan.

Medicaid makes every effort to provide complete and accurate information regarding a member's enrollment in a managed care plan. However, it is the provider's responsibility to verify eligibility and plan enrollment for a member before providing services. Eligibility and plan enrollment information for each member is available to providers from several sources.

1-3 Definitions

Definitions of terms used in other Medicaid programs are available in *Section I: General Information of the Utah Medicaid Provider Manual* (*Section I: General Information*). Definitions specific to this manual are provided below.

The information found in the Speech-Language Pathology and Audiology Licensing Act, Title 58, Chapter 41, may supersede the definitions below.

Audiologist: An individual specifically trained and licensed to perform the functions of an audiologist as described in the State of Utah Speech Pathology and Audiology Licensing Act Title 58, Chapter 41.

Audiology aide: An individual who meets the minimum qualifications as described in the State of Utah Speech Pathology and Audiology Licensing Act Title 58, Chapter 41. Who does not act independently and works under the personal direction and direct supervision of a licensed audiologist who accepts responsibility for the acts and performance of that audiology aide.

Direct supervision/immediate supervision: The supervising licensee is present and available for face-to-face communication with the person being supervised when and where services are being provided.

Speech-Language Pathologist or Speech Therapist: An individual specifically trained and licensed to perform the functions of a speech-language pathologist as described in the State of Utah Speech Pathology and Audiology Licensing Act Title 58, Chapter 41.

Speech-Language Pathology Aide: An individual who meets the minimum qualifications as described in the State of Utah Speech Pathology and Audiology Licensing Act Title 58, Chapter 41. Who does not act

independently and works under the personal direction and direct supervision of a licensed speech-language pathologist who accepts the responsibility for the acts and performances of that speech-language pathology aide.

2 Provider Participation Requirements

A speech-language pathologist and/or audiologist must hold a current professional license in the State of Utah, may provide services only in that licensed specialty, and may supervise according to State Licensing Law. A speech-language pathologist and/or audiologist must be enrolled with the Utah Medicaid Program to receive Medicaid reimbursement for services.

Speech-language and/or audiology students in their final Clinical Fellowship Year (CFY) may provide Medicaid services under general supervision, but Medicaid billing must be done by a speech-language pathologist and/or audiologist.

2-1 Provider Enrollment

Refer to provider manual, *Section I: General Information* for provider enrollment information.

3 Member Eligibility

A Medicaid member is required to present the Medicaid Member Card before each service, and every provider must verify each member's eligibility each time and before services are rendered. For more information regarding verifying eligibility refer to provider manual, Section I: General Information, Chapter 5, Verifying Medicaid Eligibility.

4 Program Coverage

Procedure Codes
Procedure codes, with accompanying criteria and limitations, are now found on the Medicaid website Coverage and Reimbursement Lookup Tool at https://medicaid.utah.gov.

4-1 Covered Services

4-1.1 Speech-Language

Plan of care required

A written plan of care established by the speech-language pathologist is required. The plan of care must include:

- Patient information and history
- Current medical findings
- Diagnosis
- Previous treatment (if applicable)
- Planned treatment
- Anticipated goals
- The type, amount, frequency and duration of the services to be rendered

EPSDT eligible members also require:

Scores of appropriate tests that measure the disability or dysfunction must be submitted with the plan of care annually.

Speech Evaluation

EPSDT eligible members and pregnant women are allowed one speech evaluation per year.

Speech Augmentative Communication Devices

For information regarding speech augmentative communication devices, refer to provider manual, *Medical Supplies and Durable Medical Equipment, Prosthetic Devices*. Information regarding specific codes can be found on the Medicaid website Coverage and Reimbursement Lookup Tool at: https://medicaid.utah.gov. Up to three speech therapy visits will be authorized during the 30-day trial period of a speech-generating device with documentation of trial period. The regular speech therapy codes must be used.

Voice Prosthetics and Voice Amplifiers

For information regarding voice prosthetics and voice amplifiers, refer to provider manual, *Medical Supplies and Durable Medical Equipment, Prosthetic Devices*. Information regarding specific codes can be found on the Medicaid website Coverage and Reimbursement Lookup Tool at: https://medicaid.utah.gov. A speech-language pathologist may provide necessary training for utilization of the device. The regular speech therapy codes must be used.

A. Covered Speech-Language Services - EPSDT Eligible and Pregnant Women

Overview

Services include examination, diagnosis, and treatment of speech/ communication disabilities and related factors of individuals with certain voice, speech, hearing, and language disorders. These services treat problems associated with accident, injury, illness, or birth defect. Nonorganic or organically based speech-language articulatory deviations, voice disorders, language impairments, or dysfluencies may be included in the treatment plan in some specific instances.

B. Covered Speech-Language Services - EPSDT Eligible

State funds other than Medicaid, support speech and language therapy through Early Intervention for ages 0 to 3 years.

The goal is to help parents prepare their child for preschool and kindergarten if there is a speech or language disorder present. The State Office of Education, not Medicaid, funds speech and language services provided in the education system for children from preschool (age 3 years) through grade 12.

- Services for children ages 2 years through 5 years are covered, if the child's speech or language deficit is at, or greater than one and one-half standard deviations below the mean as measured by an age appropriate standardized test for articulation, phonology, fluency or language OR if using percentile score is at or below the 7th percentile. The services will be limited to one group or individual session per week for six months or less as designated in the plan of care, unless the medical need for more services is documented. One and one-half standard deviations below the mean equals a standard score of 78.

- Services for children ages 6 years through 20 years are available through the educational system, but additional Medicaid services may be approved if the child's speech or language deficit is at, or greater than two standard deviations below the mean as measured by an age appropriate standardized test for articulation, phonology, fluency or language OR if using percentile score is at or below the 2nd percentile. The services will be limited to one group or individual session per week for six months or less as designated in the plan of care unless the medical need for more services is documented. Two standard deviations below the mean equals a standard score of 70.
- Services for children under age 2 are not covered unless a specific medical diagnosis and the documentation supports the need and efficacy of early intervention for speech therapy. There must be a medical reason requiring such early intervention. The criteria found in the first bullet point (ages 2-5 years) applies if testing is possible.
- Services for voice anomalies such as pitch, tone, or quality, are limited to velopharyngeal inadequacies due to cleft palate, submucous cleft palate, congenital short palate, palatopharyngeal paresis/paralysis, neuromuscular diseases (myasthenia gravis, multiple sclerosis, ALS, etc.).
- Services for voice disturbances related to vocal cord pathology or vocal cord dysfunctions are limited to 5 visits. This includes vocal cord nodules, polyps, web, mucosal edema, or granulomatosis or vocal cord dysfunctions of paralysis/paresis, hyper and hypokinesis, laryngeal dystonia, or paradoxical vocal fold dysfunction.
- Feeding and food aversion therapy is limited to up to 10 visits, unless the medical need for more services is supported by documentation that the child's weight is below the 10th percentile for their age appropriate weight. (See CDC charts for age appropriate weights).
- Dysphagia therapy is limited to 3 visits. Each visit consists of a single 1-hour treatment per week for three weeks with the care-giver present.
- The initial training for communication boards, such as PECS or picture boards, is limited to 3 training visits. Continued training is not covered.

C. Covered Speech-Language Services - Adult Pregnant Woman

Medicaid policy allows:

- Diagnostic treatment for purposes of evaluation in instances where definitive examinations and tests are not possible to administer because of the condition of the recipient
- Fifteen (15) annual visits
- Initiating treatment without delay, where an evaluation indicates the need for immediate service.
- Dysphagia therapy is limited to 3 visits. Each visit consists of a single 1-hour treatment per week for three weeks with the care-giver present.

Speech Therapy for Cognitive Therapy

Available with a diagnosis of either:

- Cerebral vascular accident (CVA) - Treatment must begin within 90 days of the incident.

- Traumatic Brain Injury - Treatment must begin within 18 months of the injury.

Speech therapy for cognitive purposes must be ordered by a physician and must include a plan of care. Speech therapy for cognitive disorders should typically begin after speech therapy for dysphagia and motor function speech issues have been addressed. The care giver, if possible, must attend the therapy sessions to receive instructions to work with the recipient and reinforce therapy and conduct repetitions with the patient.

Therapy is limited to twelve (12) visits over 60 days and one per month for the following three months for a maximum total of 15 visits annually. Use code 92507 when billing.

4-1.2 Audiology Services

A. Covered Audiology Services - EPSDT Eligible and Adult Pregnant Woman

Overview

Audiology services include preventive care, screening, evaluation, diagnostic testing, hearing aid evaluation, and prescription for a hearing aid, ear mold services, fitting, orientation and follow-up. A hearing aid battery provision is included in these services. Audiologic habilitation includes, but is not limited to speech, hearing, and gestural communication.

Medicaid reimburses two primary services and one subsequent service for Medicaid clients: a diagnostic examination, an assessment for a hearing aid(s) and, when appropriate, a hearing aid or assistive listening device. Medicaid also reimburses repairs on hearing aids.

Examination and Assessment

Diagnostic audiology evaluations require a written physician's order and include procedures which may be used for a hearing aid assessment and any other diagnostic tests appropriate for the specific diagnosis as ordered by the physician.

Medicaid supports the nationally recommended strategy to have all infants receive a hearing screen**.** Use code V5008 for a hearing screening (otoacoustic test) for infants under one year of age.

If a recommendation for a hearing aid assessment is made, a written physician's referral or request is required. If subsequent hearing testing shows a change in the hearing thresholds or the need for a new hearing aid, then medical clearance must be obtained before proceeding with the hearing aid refitting.

The purpose of the physician's medical clearance is to determine if the change requires medical intervention; if not then a hearing aid assessment may be performed with a referral. The hearing aid assessment, to determine candidacy for amplification, must include the following: pure-tone air conduction and bone conduction thresholds; speech reception thresholds and speech discrimination scores for each ear; most comfortable loudness (MCLs) and uncomfortable loudness (UCLs), diagnosis as to the type of hearing loss for each ear (i.e. conductive, sensorineural, or mixed), and the pure-tone average (PTA) loss for 500 Hz, 1000 Hz, and 2000 Hz in each ear.

Hearing Aids

Hearing aids require prior authorization (see *6-1.2 Audiology Services, Prior Authorization*). The hearing aid may be provided by an audiologist or by a provider of hearing aid supplies. All services, including conformity evaluation and initial ear molds, are included in each rate to cover a period of 12 months.

Assistive Listening Device

Assistive listening devices require prior authorization. The hearing loss criteria are the same as that for hearing aids. This device can be provided in lieu of a hearing aid for clients who are not capable of adjusting to a hearing aid. If the client meets the hearing loss criteria, the audiologist shall look at various facts including the client's ability to care for hearing aids, whether the client will wear the hearing aid, whether the client desires a hearing aid, and what are the expected results, in order to determine whether a hearing aid or an assistive listening device would be the most appropriate item, to meet the hearing needs of the client. This does not include a frequency modulation (fm) or radio frequency (rf) system.

Cochlear Implants

Cochlear implants are an optional service available to EPSDT (CHEC) recipients and pregnant women. Bilateral cochlear implants are available to EPSDT (CHEC) recipients if the service is determined to be medically necessary.

5 Non-Covered Services and Limitations

For further information and additional non-covered services and limitations refer to the Coverage and Reimbursement Lookup Tool on the Medicaid website at: https://medicaid.utah.gov.

5-1 Non-Covered Services

5-1.1 Speech-Language

A. **Non-Covered Speech-Language Services - EPSDT Eligible and Adult Pregnant Woman**

The following services are not Medicaid benefits:

Treatment for -

- Social, education, or developmental needs.
- Recipients who have stable, chronic conditions which cannot benefit from communication services.
- Recipients with no documented evidence of capability or measurable improvement.
- Residents of an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) (included in the per diem resident rate).
- Voice anomalies such as pitch, tone, quality, or rhythm, except when due to accident, illness, birth defect, or injury.
- Non-diagnostic, non-therapeutic, routine, repetitive or reinforcing procedures, such as practicing word drills or using a communication board, such as a PECS, or picture board or other procedures that may be carried out effectively by the patient, family, or care givers.

B. **Non-Covered Speech-Language Services - EPSDT Eligible**

The following conditions are not covered services, except when related to accident, illness, birth defect, or injury:

- Continued training beyond the initial instruction to use a communication board, such as a PECS, or picture board.
- Self-correcting dysfunctions that are within normal limits for the recipient's age. For example: slow speech development, developmental dysfluencies, or developmental articulation errors.
- Dysfluencies such as stuttering or stammering or rhythm abnormalities.
- Articulation problems, such as "lisping" or the inability to provide certain consonants.

5-1.2 Audiology Services

Non-Covered Audiology Services - Adult Pregnant Woman

Refer to *5-2 Audiology Services – Limitations*.

5-2 Limitations

5-2.1 Speech-Language

These services are limited as described below.

EPSDT Limitations

- Home health speech therapy, unless the recipient is unable to leave the home for outpatient speech therapy.
- Communication disabilities solely associated with behavioral, learning, and/or psychological disorders, unless documented as part of a comprehensive medical treatment plan.
- Treatment for clients who have reached maximum potential for improvement or who have achieved the stated goals, or now test above the stated threshold requirements for treatment.
- Treatment for CVA or TBI which begins more than six months after onset.

5-2.2 Audiology Services

Examination and Assessments

Diagnostic audiology examinations and hearing aid assessments must be performed with a physician's order. Exams must be documented as medically necessary in each case.

Hearing Aids

- Hearing aids must be guaranteed by the manufacturer for a period of at least one year.
- The initial ear mold, fitting of the hearing aid on the recipient, and necessary follow-up procedures (i.e. conformity evaluation, counseling, adjustments, testing batteries, etc.) are part of the global rate and will not be reimbursed separately. The global rate covers a period of twelve months.
- If a follow-up examination results in a recommendation for a different model of hearing aid, the original aid must be exchanged for another aid within the 60 days allowed by retailers. No rental may be charged.

- The provider must accept the return of a new hearing aid within 60 days if the physician or audiologist determines that the hearing aid does not meet specifications.
- Services requested for patients who reside in an ICF/ID facility are the responsibility of the facility under "active treatment" regulation. Exception: This does not include the provision of the hearing aid appliance which may be billed separately to Medicaid.
- The physician's statement must be retained on file by the provider of the hearing aid for a period of three years.
- Hearing aids may be replaced every five years when medically appropriate. Exceptions may be made for unusual circumstances, e.g., accident, surgery, or disease.

Hearing Aid Replacement, Repair and Rental

Replacement

Hearing aid replacement is authorized when medically necessary at an interval of three years for EPSDT-eligible beneficiaries. When requesting a replacement hearing aid, a new medical examination, referral letter, and audiology evaluation is required. Documentation showing the Manufacturer Suggested Retail Price (MSRP) must be submitted with the prior authorization request.

Repair

- Hearing aid repairs and related services do not require prior authorization.
- Repairs over $15.00 must be itemized. Medicaid will only reimburse the actual cost of the parts.
- Medicaid reimburses using code V5014 for hearing aid repairs. If the repair is sent out of a vendor's facility for repair, the vendor will be reimbursed for the manufacturer's invoice plus an additional $15. When billing, attach a copy of the manufacturer's original invoice to the request.

  If the repair is completed by the vendor directly, the vendor will be reimbursed for the vendor's invoice which must include the cost for time and parts, plus an additional $15.
- Hearing aid repairs are only available to EPSDT eligible members and pregnant women.

Rental

Prior authorization is required for hearing aid rental. If a hearing aid must be sent away for repair Medicaid will pay for a rental hearing aid if a recipient requires a "loaner" hearing aid. This service is not to exceed two months.

6 Billing

For detailed billing instructions, refer to the provider manual, *Section I: General Information*.

Speech-language pathology services and audiology services are reimbursed using the fee schedule found at the Utah Medicaid website at https://medicaid.utah.gov, Health Care Providers, Coverage and Reimbursement tools, Coverage, Coverage and Reimbursement Lookup-Tool.

6-1 Prior Authorization

6-1.1 Speech-Language

All therapy sessions require prior authorization (PA). Failure to obtain prior authorization can result in payment denial by Medicaid. Providers must determine if prior authorization is necessary and obtain authorization *before* providing services. Exceptions may be made, with appropriate documentation, if the service provided is emergent or the member is retro-eligible for the dates of service requested.

Prior authorization information is provided in the provider manual, *Section I: General Information* found at https://medicaid.utah.gov.

A prior authorization request includes a Request for Prior Authorization form (PA Request) and a plan of care for the patient or a document outlining all of the following:

- Diagnosis and severity of the condition
- Prognosis for progress
- Objectives of the specific treatment
- Detail of the method(s) of treatment
- Frequency and length of treatment sessions and duration of the program

Prior authorization will be given for a maximum of a six month treatment period.

Extended Service Requests

A new prior authorization request must be submitted for an extended service request. The request must include the same elements as the first PA request as well as a:

- New plan of treatment
- Progress report on the previous treatment objectives
- Medical evaluation from both the clinician and the physician
- The evaluation includes supplemental data such as:
  - Post-treatment progress made
  - Family problems that may hinder progress
  - Expected treatment termination date

6-1.2 Audiology Services

Prior Authorization Request Requirements - Hearing Aids

To receive prior authorization all the following are required for EPSDT eligible members and pregnant women.

1. A physician's order stating the patient has been medically cleared for hearing aid use. Retained in the patient's file.
2. The results of a comprehensive audiometric exam performed by the audiologist to identify the kind of hearing loss (i.e. conductive loss, sensorineural loss, or mixed loss), speech testing to include the speech reception thresholds and speech discrimination scores, and the pure-tone average.

3. The kind of hearing loss, conductive loss, sensory-neuro loss, or mixed.
4. The type of hearing aid requested; monaural or binaural, and the respective code.
5. An audiogram or form that reports the hearing evaluation test or decibel loss will include for both right and left ears: Hearing thresholds at 250, 500, 1000, 2000, 4000 and 8000 Hz.

Additional information for EPSDT Eligible Members (18 years and older) and Pregnant Women:

1. If the hearing test shows an average hearing loss in one ear of 35 dB or greater, based on the standard PTA (500, 1000, 2000 hertz) for that ear, a monaural aid may be authorized.
2. Binaural hearing aids are reimbursed only under one of two circumstances:
   - Must be verified with an average hearing loss of 30 dBs based on the standard PTA for both ears
   - The recipient is blind, and a monaural hearing aid may be contraindicated.

Additionally, EPSDT Eligible Members (17 years and younger) also require:

1. The high frequency pure-tone average.
2. If the hearing test shows an average hearing loss in one ear of 30 dB or greater, based on a high frequency PTA specially calculated for frequencies 1000, 2000, and 4000 hertz for that ear, a monaural aid may be authorized.
3. Binaural hearing aids are reimbursed only under one of two circumstances:
   - Must be verified with an average hearing loss of 25 dBs, based on a high frequency PTA specially calculated for frequencies 1000, 2000, and 4000 in both ears.
   - The recipient is blind, and a monaural hearing aid may be contraindicated.

Note: A binaural hearing aid is one unit for billing purposes.

Brain Stem Testing

When a child is cannot be tested by normal audiometric means, generally an Audiological Brain Response (ABR) is administered. This test measures responses in the 2000-4000 Hertz range.

If the ABR results are abnormal or show no response, the results of an Otoacoustic Emissions test (Newborn hearing test) and a Visual Response Audiometry test (or other similar conditioned response audiometry test) will be required to confirm the results of the ABR. All tests must confirm the need for amplification.

Newborn screening

Screening for newborn babies, as mandated by Utah S. B. 40, will be reimbursed by the following means:

- If the hospital performing the newborn delivery is a DRG hospital, the auditory screening is included in the DRG and the audiologist is reimbursed by the by the hospital from the DRG funds paid by Medicaid.
- If the hospital performing the newborn delivery is a non-DRG hospital or the delivery occurs in a nonhospital setting, the audiologists may bill Medicaid for the auditory screening.
- If the screening does not take place at birth and the infant is screened at a subsequent date, the audiologist may bill Medicaid for the auditory screening.

Use code V5008 for reimbursement for non-DRG non-Hospital setting or screening outside of a hospital. Do not bill using CPT codes for screenings.

7 References

Current Procedural Terminology, American Medical Association, current edition

Utah Administrative Code, Title:

R156-1, General Rule of the Division of Occupational and Professional Licensing

R156-1-102a, Global Definitions of Levels of Supervision

R156-41, Speech-Language Pathology and Audiology Licensing Act Rule

R414-1-6 (q), Services Available

Services for individuals with speech, hearing, and language disorders, 42 CFR §440.110(c)

Standard: Plan of Care, 42 CFR § 485.711(b)

Utah Code Title 58, Chapter 41, Section 1

Utah Code, Section: 26-18 Medical Assistance Act #18-3 and 18-5

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